South Carolina Department of Health and Human Services
MEDICAID APPLICATION FOR

☐ Nursing Home ☐ Waiver Services ☐ General Hospital

County Name: _____ Case Number: _____ Date Received: _____

The following information is needed so that a determination of eligibility for Medicaid can be made. Any information given is subject to verification. At the end of this form you will be asked to sign a statement that you understand the questions and that you have answered all the questions fully and completely, to the best of your knowledge, and that you have not given any false information. Please answer all questions unless otherwise instructed.

1. Answer these questions if you are making this application for someone else.

Your Name: _____ Relationship to Applicant: _____

Your Address: _____ Home Phone Number: _____

_____ Work Phone Number: _____

_____

Do you or anyone else have any of the following for the applicant? ☐ Yes ☐ No

☐ Conservatorship ☐ Guardianship ☐ Power of Attorney

If yes, please give us a copy of the court papers and the name of the person if someone other than you.

Name: _____

2. Who is the person needing assistance (Applicant)? ☐ Aged (Age 65 and older)

_____ ☐ Disabled ☐ Blind

First Middle Last

Home Address Mailing Address (if different) Home Phone Number

_____ _____ _____

_____ _____ Work Phone Number

_____ _____ _____

Where is the applicant physically located now? _____

If in a medical facility, what was the date of admission? _____

Please give the following information about the applicant:

Date of Birth (Mo/Day/Year)	Sex	Race	SC resident (Yes or No)	US citizen (Yes or No)	Marital Status	Social Security Number	Social Security or Railroad Retirement Claim Number

3. Give the following information about the applicant's spouse and children under 21.

Name	Relationship	Birthday (Mo/Day/Yr)	Sex	Race	SC Resident (Yes or No)	Marital Status	Social Security Number (Optional)	Social Security or Railroad Retirement Claim Number (Optional)

4. Is the applicant/spouse/minor child(ren) receiving or applying for income from any of the following?

Check Receiving or Applied For (Yes or No)	Receiving		Applied For	
	Yes	No	Yes	No
Supplemental Security Income (SSI)				
Social Security Income (RSDI)				
Veteran's Administration Benefits (VA)				
South Carolina State Retirement				
Civil Service				
Other Pension or Retirement Income				
Child Support or Alimony				
Interest, Dividends, Trust or Annuity Income				
Rental Income				
Money from Loans, Promissory Note, or Mortgage				
Money from Relatives, Friends, or Boarders				
Payment Made to a Medical Facility on Applicant's Behalf				
Workman's Compensation				
Unemployment Compensation				
Work/Training/Self-Employment				

If you answered yes to any of the above complete the following:

Income Source	Who is the Money For	Amount	How Often Received

5. Does the applicant or spouse receive any money or checks that we have not asked about? ☐ Yes ☐ No

If yes, explain: _____

_____

6. Is the applicant a veteran? ☐ Yes ☐ No VA Claim Number: _____

Is the applicant's spouse a veteran? ☐ Yes ☐ No VA Claim Number: _____

7. If the applicant is disabled, is it due to an accident? ☐ Yes ☐ No ☐ Not Disabled

If yes, when and where did the accident occur? _____

_____

Was there or will there be any compensation to the applicant? ☐ Yes ☐ No If yes, explain: _____

_____

8. Does the applicant or spouse have any of the following assets or resources?

Item	Yes	No	Item	Yes	No
Checking Account			Car, Truck, Van, Motorcycle, Boat, Mobile Home		
Savings Account			Farm Machinery or Business Equipment		
Certificate of Deposit			Holder of a Mortgage or Promissory Note		
Trust Fund or Trust Account			Cash on Hand		
Safe Deposit Box			Lump Sum Payment Within Last 3 Years		
Stocks, Bonds, or Mutual Funds			Other (Identify):		
401K, IRA or other Retirement Account					

If yes, complete the following about each:

Owned By	Type of Account - or - Type of Asset	Account Number - or - Asset Description	Current Value or Balance	Name and Address of Institution

9. Does anyone maintain a bank account, or any other asset, for the applicant or spouse? ☐ **Yes** ☐ **No**

If yes, at what bank or location, and in whose name(s)? _____

10. Does the applicant or spouse own any property including a home, land or other building(s)? ☐ **Yes** ☐ **No**

If yes, complete the following:

Address/Location of Property:	Address/Location of Property:
Owner(s): Homestead: ☐ Yes ☐ No Intent to Return Home? ☐ Yes ☐ No	Owner(s): Homestead: ☐ Yes ☐ No Intent to Return Home? ☐ Yes ☐ No

11. Does the applicant or spouse share ownership in any property? ☐ **Yes** ☐ **No**

Does the applicant or spouse own lifetime rights to any property? ☐ **Yes** ☐ **No**

If yes, where is the property located and whose name is it in?

_____

_____

_____

12. Does the applicant or spouse own any life or burial insurance? ☐ **Yes** ☐ **No**

This includes any policies purchased for someone else

Owner of Policy	Person Insured	Name of Company	Policy Number	Face Value

13. Does the applicant or spouse have any of the following burial assets?

Asset	Yes	No	Description and Location of Asset
Pre Need Burial Contract			
Burial Account			
Money Set Aside for Burial			
Cemetery Burial Lot			

Other information: _____

_____

14. Is the applicant or spouse covered by any other medical insurance, including Medicare or coverage purchased by someone else? ☐ **Yes** ☐ **No** *If yes, complete the following and provide a copy of the card, policy and/or premium notice.*

Person Insured	Name of Company	Policy Number	Type of Policy

15. Did the applicant receive medical services in the previous three (3) months? ☐ **Yes** ☐ **No**

If yes, complete the following:

Date of Service	Provider of Services (Doctor, Hospital, Drug Store, etc.)

16. Were the applicant's financial situation and living arrangements the same in the previous three (3) months as it is now? ☐ **Yes** ☐ **No** **If no, explain how they were different:** _____

_____

_____

17. Does anyone for whom you are applying have a plastic South Carolina Partners for Health (Medicaid) card?
☐ **Yes** ☐ **No** **If yes, please list the names here:** _____

18. Where has the applicant lived in the past five (5) years?

City	County	State	From	To

19. If ever married, give the following information about the applicant's spouse(s), listing the most recent first.

Name:	Phone Number:	
Address:	☐ Living ☐ Married living together ☐ Married separated ☐ Divorced	☐ Deceased Date of Death: _____ County and state where estate was probated:
If separated, how long:	If Divorced, date and place divorce filed:	
Name:	Phone Number:	
Address:	☐ Living ☐ Married living together ☐ Married separated ☐ Divorced	☐ Deceased Date of Death: _____ County and state where estate was probated:
If separated, how long:	If Divorced, date and place divorce filed:	

20. Give the following information about the applicant's mother and father if known.

Mother:	☐ Living
Address:	☐ Deceased Date of Death: _____ County and State where estate was probated:
Father:	☐ Living
Address:	☐ Deceased Date of Death: _____ County and State where estate was probated:

21.Complete the Following:

Where did the applicant work the longest?	**Where did the applicant last work?**
Employer's Name and Address:	Employer's Name and Address:
Dates of Employment: Does applicant receive a pension? ☐ Yes ☐ No	Dates of Employment: Does applicant receive a pension? ☐ Yes ☐ No

22. Has the applicant or spouse had any other bank accounts in the past three years (five years if placed in a trust)?
☐ Yes ☐ No *If yes, at what bank and in whose name(s)?*

A. _____ B. _____

Date Closed: _____ Closing Balance: _____ Date Closed: _____ Closing Balance: _____

23. Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person within the past 36 months (60 months if assets placed in a trust)? ☐ Yes ☐ No

Item Sold or Given Away	Person to Whom it was Sold or Given	Date Given or Sold	Amount Received

24. If married and entering a nursing home, does the applicant want to give (allocate) part or all of income to spouse remaining at home? ☐ Yes ☐ No

25. If you do not know the answers to all questions, is there another person who can give more information?
Name: _____ Telephone: _____
Address: _____

For DHHS Use Only

Burial Exclusion for: _____

Pre Need Burial Contract
Name of Funeral Home: _____ ☐ Irrevocable ☐ Revocable
Burial Space Items: $_____ Burial Fund Items: $_____ Date of Contract: _____

Burial Fund Exclusion
List the asset(s) designated for burial and its value:

_____
_____
_____
_____
_____

Total amount designated: $_____ Excluded: $_____ Non Excluded: $_____

I UNDERSTAND THAT IF ANY EXCLUDED BURIAL FUNDS ARE USED FOR ANY PURPOSE EXCEPT BURIAL, AN AMOUNT EQUAL TO THE AMOUNT USED FOR SOME OTHER PURPOSE WILL BE COUNTED AS INCOME IN DETERMINING ELIGIBILITY FOR ASSISTANCE.

SIGNATURE: _____ Date: _____

STATEMENT OF RIGHTS AND RESPONSIBILITIES

Read each statement carefully. If you do not understand some of the statements, you should ask the worker to explain.

- In accordance with Federal law and U. S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.
- To file a complaint of discrimination, write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S. W., Washington, D. C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.
- The case record is confidential, and no information will be released without your permission, except as provided for under state and federal laws. Eligibility may be shared by DHHS if it will help get other benefits for the applicant.
- The applicant may request a hearing if the applicant believes that the State of South Carolina has made an error in processing the applicant's case.
- Any information given to the Department of Health and Human Services is subject to verification. Full cooperation is required in the event Eligibility Quality Assurance selects this case for review.
- Changes in income, resources and living arrangements must be reported within ten (10) days of the date of the change(s). Failure to notify the department promptly may be considered fraud, which is a crime punishable under state law.
- If found guilty of fraud, the penalty is a fine up to $1000 or imprisonment up to three (3) years or both.
- Release of medical records to the Department of Health and Human Services is authorized. A copy of the authorization shall be as valid as the original.
- The Department of Health and Human Services will request and use information available through the computerized state Income and Eligibility Verification System (IEVS). This system matches the department's information about the applicant and other members of the family with information from other agencies such as the Internal Revenue Service (IRS), Social Security Administration (SSA) and the Employment Security Commission (ESC). Information obtained through IEVS may affect eligibility.
- By applying for medical assistance, any rights to medical support or other payments for medical care are assigned to the state. If application is made for minor children, cooperation with the state is required in establishing paternity and in obtaining third party payments.
- The Department of Health and Human services will seek recovery from the estate of the Medicaid beneficiary who:

  1. at the time of death was an inpatient in a nursing home facility, intermediate care facility for the mentally retarded, or other medical institution; and was required as a condition of receiving services under the state plan, to spend for costs of medical care all but a minimal amount of the person's income required for personal needs, or
  2. was fifty-five years of age or older when the individual received medical assistance, but only for medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services received while the individual was in a nursing facility or receiving home and community based services.

TURN TO THE NEXT PAGE AND SIGN.

Complete the Following:

- I certify that I have read, or had read to me, all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given false information or have withheld any information regarding any situation, I am liable for prosecution for fraud and/or perjury. I hereby give the department permission to verify, without additional consent from me, information discovered by the department or given by me that is needed to determine eligibility. **(This form is not considered valid unless signed.)**
- **Unless otherwise noted, I certify that the persons named on the front of the application are United Sates citizens or in lawful immigration status. I understand that immigration status will be verified with the Department of Homeland Security (DHS).**

Applicant/Beneficiary's Signature:		Date:
Responsible Person or Authorized Representative's Signature:	Title/Relationship:	Date:
Witness: *(Signature by mark of "X" requires two witnesses)*	Address:	Date:
Witness:	Address:	Date:
If you have decided not to continue with your application, complete the following: I have decided not to continue with my request and my signature below means that I want to withdraw my application for Medicaid.		
Signature:		Date:

Referrals Discussed:

- ☐ Supplemental Security Income Program
- ☐ Adult Services
- ☐ Other: _____

Forms Given to Client:

- ☐ Civil Rights Pamphlet
- ☐ Medicaid Handbook
- ☐ Estate Recovery
- ☐ Fair Hearing & Appeals
- ☐ Other: _____

DHHS Worker's Signature	Date:

Remarks: _____